VERMONT

DOL FORM 23 (Rev. 5/05)

State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Fed. ID No. _____

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

AGREEMENT FOR COMPENSATION IN FATAL CASES

IT IS AGREED, between _____, ****spouse**, **** reciprocal beneficiary, **dependent**, ***guardian** of the dependents of _____, the deceased employee of _____

_____
Street, Rural Route, Box Number,

_____ *AND* _____, the ****insurance carrier/**employer**,
City, State, Zip

By reason of the fatal accidental injury suffered on _____, 20 _____, by the said employee while in the employ of _____ of the city/town of _____, in the County of _____ and State _____ causing the following injury: _____

from which death resulted on _____, 20 _____

MEDICAL, HOSPITAL AND SURGICAL SERVICES

That the employee shall receive medical, hospital, surgical and nursing services and supplies in accordance with the provisions of 21 V.S.A. § 640. The expense of such services and supplies shall be borne by the insurance carrier/employer.

BURIAL EXPENSE

It is agreed that the deceased employee's burial expense shall be borne by the ****insurance carrier/**employer**, in accordance with the provision of 21 V.S.A. § 632, as amended.

DEPENDENTS

It is agreed that the following persons were dependent upon the deceased employee for support and by reason of his /her death are entitled to compensation as provided by law:

Name	Relationship	Date of Birth

WEEKLY COMPENSATION

It is agreed that the employee's average weekly wage for the twelve weeks before the injury was $ _____ and that said dependents are entitled to _____ % (percent) of said average weekly wage, the sum of $ _____ and that said beginning _____, 20 _____ and continuing until a change in the condition of dependency occurs, after which the amount due weekly shall be redetermined. The period of payment shall not exceed the limits set forth in 21 V.S.A. § 635, as amended.

APPROVAL AND REVIEW

This agreement or any settlement thereunder shall not be binding or operative unless and until this agreement and such settlement is approved by the Commissioner of Labor.

_____ *Insurance Adjuster Name (Print)*

_____ *Insurance Adjuster Signature*

_____ *Official Title* *Date*

_____ *Spouse, Reciprocal Beneficiary, Dependent or Guardian of Dependents*

_____ *Date*

APPROVED: _____, 20 _____

_____ *Commissioner of Labor/Designee*

****Strike out inappropriate expressions.**